# LEAVE ELECTION FORM

DATE: _____

TO: DOAS/Division of Risk Management Services
Workers' Compensation Unit
P.O. Box 38198, Capitol Hill Station
Atlanta, GA 30334

FROM: _____
(Injured Employee's Name – Please Print)

_____
(Date of Injury)

_____
(Contact Number)

RE: Workers' Compensation Payments

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On _____ (Date of Injury), I was injured on the job while working for the _____ (Agency Name). If I have to lose any time because of this injury, I request that I be paid as follows:

☐ From my accumulated sick leave, and if necessary, from accumulated annual leave, before receiving Workers' Compensation benefits for loss of wages. I understand that when I have used my accumulated sick and annual leave, I will receive Workers' Compensation benefits if I am still unable to work due to the injury.

☐ Workers' Compensation benefits for loss of wages instead of full pay from accumulated sick and annual leave to be paid in regular bi-weekly installments. Effective: _____ (Date).

☐ From my accumulated sick leave, and if necessary, from my accumulated annual leave through _____ (Date) at which time I wish to be paid Workers' Compensation benefits for lost wages.

_____
Signature of Injured Employee

_____
Date

IF A MARK IS USED, TWO WITNESSESS ARE REQUIRED:

(1) _____

(2) _____

Revised: 11/14/03